



The CAFP Medical Home *Muse*

Rediscover the Art of Medicine

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Profiles of Change

Tracy S. Hofeditz, MD



Editor's Note: Profiles of physicians who are leading the movement toward Patient Centered Medical Homes are a regular feature of this newsletter. Tracy S. Hofeditz, MD, practices at Belmar Family Medicine in Lakewood, providing ambulatory primary care that does not include obstetrics but does include hospital admissions only for newborns. Dr. Hofeditz is supported by a mid-level professional, he is seeking a second Family Physician and he shares some contracting resources with other primary physicians through an independent practice association, Primary Physician Partners. Dr. Hofeditz is a participant in the Colorado Patient Centered Medical Home Pilot.

When did you begin to provide patients with a Patient Centered Medical Home?

That's difficult to answer. Many of the principles of the medical home are an evolution of the principles of Family Medicine. So, in many respects I've been providing a medical home my entire career.

However, the concepts of the Patient Centered Medical Home, as defined and detailed by the National Committee for Quality Assurance, are concrete goals that have helped define what I think is the future of our specialty: enhanced access and communication, better chronic disease management, engaging and supporting the patient in better self-care, use of electronic systems to support decisions and reduce errors, and, most importantly, better access to and use of data to guide practice change and improvement.

How did you learn about the PCMH approach to medicine?

The PCMH has been widely presented and well supported by several organizations with which I am involved. These include the American Academy of Family Physicians, the Colorado Academy of Family Physicians and the Colorado Clinical Guidelines Cooperative. The mission of CCGC is to support the improvement of primary care services in Colorado with evidence based guidelines and other support services. The Improving Performance in Practice program supported me in making changes that are consistent with the medical home. Then, CCGC recognized my readiness and encouraged me to participate.

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Building Team Med

R.Scott Hammond, M.D.,
Chair, CAFP PCMH Task Force

Tips and ideas

“As for the best leaders, people do not notice their existence. The next best, the people honor and praise. The next, the people fear and the next, the people hate. When the best leaders work is done, the people say, we did it ourselves.” Lao Tsu

Tip# 4: Understand the Planned Care Model

- Escaping the Tyranny of the Urgent by Delivering Planned Care <http://www.aafp.org/fpm/20060500/37esca.html>

LINKS

- 1** [Medical Home Forum for physicians](#)
- 2** [Conferences and Events](#)
- 3** [CAFP Medical Home](#)

Follow the tips and links starting with the first newsletter and become a PCMH in a kind and gentle way

Profile in Change: (cont)**Why did you decide to utilize the approach in your practice?**

Just when we need it most, primary care -- including Family Medicine -- is in a state of rapid decline. As a family doctor, I have been struggling to survive financially and psychologically. I have seriously considered abandoning my career. In the PCMH movement, I have found an opportunity to change the way I practice medicine for the better, to maintain my commitment to and relationship with my patients and to find joy in my work again.

What was the biggest challenge to getting started?

Change and improvement require effort, time and resources. Most of us are already working so hard that we have little left to devote to new initiatives. Hearing the call, seeing the need for change, and being ready to rededicate oneself to one's work -- together these constitute the biggest challenge.

What has been the biggest impact on your practice?

The PCMH depends on the continuous availability and use of practice data. We have established, maintained, and are using disease registries for diabetes and heart/stroke care. By tracking the treatment of these patients, we have been able to compare our care to others', identify weaknesses, offer better treatment and document our improvement.

Could you provide a few details about how you implement just one of the seven aspects of the PCMH?

Several components were necessary to begin using our disease registries. As lead physician, my leadership and commitment began the process. One key staff member became expert in the data input and use of the registry data and was a resource for the rest of the staff. Once established, the registry energized our work by showing us how we were improving our care and by helping us receive public recognition of those improvements from NCQA.

How have patients, insurers, staff and specialists responded to the PCMH?

The value and necessity of primary care must be recognized. Our health care system faces huge challenges that can be met only with a rededication to primary care and Family Medicine. I believe the PCMH is critical to that rededication. We must prove to the general public and to policy makers our value and necessity. By becoming a PCMH, we are in a much better position to prove ourselves.

Do you have a favorite brief anecdote relating to the PCMH?

I have always thought I was a pretty good doctor but when my practice data obtained by my staff showed I was not providing the level of care I expected, I became defensive. I feel I matured as a physician when I realized with excitement that only with data could I know how I was performing as a physician and where I needed to focus my efforts to improve.

What do you like best about living in Colorado?

My wife and I are from Washington State and have always loved the Cascades. We re-create and bring balance to our lives in the Rocky Mountains. While we miss the rain of Western Washington, I love a violent thunderstorm.

Building Team Med

R.Scott Hammond, M.D., Chair, CAFPCMH Task Force

When you get there, there isn't any there there.

Gertrude Stein

For those of you who just joined this odyssey, I have discussed the need for change, how it affects us and the mistakes of my first attempts of building a team. This report will review how I responded to these typical blunders:

1. I plunged ahead without sharing my sense of urgency with staff and colleagues. Complacency driven by past success, a lack of a visible crisis, and a lack of performance measures maintained the status quo and created a powerful barrier to change.

Action:

As with most struggles, communication issues are at the root. Different groups within the office responded to different "urgencies". So I had to identify what mattered to the physicians, front office, and back office staff etc. and address them specifically, boldly and honestly. We discussed scenarios of real malpractice cases at our staff meetings and analyzed the system breakdowns that lead to disaster.

2. I did not create a guiding committee to serve as role models, share the vision and represent the interests of the entire practice.

Action:

I invited the office manager, head nurse and referral clerk to a weekly committee meeting and gained their support. Better decisions were made and project timing more realistic. Credibility grew and the staff became more engaged. Find the right people and build trust.

3. The working team I created was hierarchal and not collaborative; therefore, it did not change the practice culture and projects stalled.

Action:

Culture changes after success, not before. All staff were given an assignment and asked to present a report at our regular meetings. Ownership was transferred and accountability realized. The atmosphere became more comfortable and ideas began to flow.

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Spotlight on Standards

The Game

9 Standards
10 Must Pass Elements
100 Points

The Winners

Level 1
25-49 Points and 5 Must Pass Elements
Level 2
50-74 Points and 10 Must Pass Elements
Level 3
75-100 Points with 10 Must Pass Elements

Muse News

CAFP members and friends of the PCMH:
Send in your stories, news, tips, helpful tools
and products, comments and humor to:
shammond@evcohs.com

- Apparently the Medicare Medical Home Pilot is on-hold. More to follow as Congress sorts things out.
- The Colorado PCMH Pilot is on track and ready to begin May 1st. Seventeen Front Range practices are busy preparing for NCQA certification. Aetna, Anthem, Cigna, Colorado Access and United are participating.
- CAFP along with CMS, Colorado Society of Osteopathic Medicine and the Colorado Chapter of AAP submitted a grant to The Colorado Healthcare Foundation to research the adoption of the PCMH and provide education and outreach to primary care and specialist physicians.
- The National Medical Home Summit, March 2-3 in Philadelphia, is offering a limited number of full or partial Tuition Scholarships to primary care physicians www.medicalhomesummit.com

[\(Team Med.....continued from page 2\)](#)

4. I did not clearly share the vision by reducing it to a simple message to give my staff a sense of direction on where we were heading and what we were doing

Action:

I borrowed the IMP slogan (...the right care, at the right time, at the right place) and introduced it to the staff over and over again. Repetition is a must. The details of vision became more understandable.

5. I did not engage other key personnel to communicate the benefits of change to all staff and providers.

Action:

I engaged all the physicians and PAs to support the PCMH by action and words in, yet, another monthly meeting. They all read the NCQA guidelines and PCMH joint principles.

6. I did not identify and confront all the major obstacles. I did not have the buy-in or cooperation of all the top leadership which sent an inconsistent message to the staff and undermined the transformation.

Action:

I had to accept the fact that I could not wear all the hats. I met with the providers, shared the vision, outlined their benefits, actively listened to concerns and made them a part of the decision making.

7. I was impatient and delivered too much, too soon and bypassed the needed successes of small victories. I did not establish short term goals.

Action:

I resurrected the PDSA model and engaged the staff to make small, rapid changes. I tried to reach out of my box and show exuberance over the results and provide guidance to continue the process.

8. I did not give enough feedback or reinforcement to transform new changes into a habit.

Action:

I asked our providers to join me and promise to notice PCMH behavior in our staff at least twice a day and make a positive comment. I try to send weekly e-mails to staff with a positive PCMH success story.

Next Month: Anyone Home?

Cool Tools

A quick kick start to your journey Home is [ReachMyDoctor](#) which provides:

- Individualized care plans, registry, flow sheets, run charts and custom reporting to improve quality and safety.
- Intra/interoffice communication with physicians, hospitals and e-mail to patients to facilitate coordination of care.
- Personal Health Record, educational links, patient reminders and more.

Studies show that patients do not abuse e-mail and it saves staff and physician time. It is free to IPIP practices and members of CCGC (www.coloradoguidelines.org) and CMS, otherwise, it is \$350/physician. Check it out at:

<http://www.rmdnetworks.com>

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